TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
THE NEURO MEDICAL CENTER CLINIC

MFDR Tracking Number
M4-16-0244-01

MFDR Date Received
September 28, 2015

Respondent Name
BITCO GENERAL INSURANCE CORP

Carrier's Austin Representative
Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Because we do not file claims via certified mail, we are unable to provide timely filing according to Bitco and Corvel's requirements. However, since these services were authorized and provided in good faith by our neurosurgeon & his assistant, we feel that our claims should be paid..."

Amount in Dispute: $32,146.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 23, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the Division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 8, 2014 through August 4, 2014	In patient facility charges	$3,1714.70	$0.00
August 4, 2014 and October 22, 2014	72040 and 99215	$432.00	$0.00
		$32,146.70	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 29 – The time limit for filing claim/bill has expired.
   - 16 – Service lacks info needed or billing error(s).
   - RG3 – Included in another billed procedure.
   - RM2 – Time limit for filing claim has expired.
   - time limit for filing claim/bill has expired
   - RM7 – Invalid code for CMS payment/resubmit w/valid code.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for dates of service, May 8, 2014 through August 4, 2014?
2. Did the requestor submit documentation to support the billing of CPT Code 99215 rendered on October 22, 2014?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   > Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   >
   > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The dates of the services in dispute are May 8, 2014 through August 4, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on September 28, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c) (1) (B). The Division concludes that the requestor has failed to timely file dates of service May 8, 2104 through August 4, 2014 with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these dates. Date of service October 22, 2014 was submitted within the one year filing deadline and therefore, eligible for review. The Division will therefore review CPT Code 99215 rendered on October 22, 2014 pursuant to the Division Fee Guidelines and applicable rules.

2. Review of the submitted documentation finds that the requestor seeks payment for CPT Code 99215 rendered on October 22, 2014. Review of the EOBs submitted by the requestor does not include documentation to support that the insurance carrier audited CPT Code 99215. The EOBs submitted indicated that the insurance carrier audited CPT Code 99245. Review of the CMS-1500 submitted by the requestor supports that the requestor billed the insurance carrier with a corrected CPT Code of 99215 and submitted the bill to the insurance carrier on September 23, 2015 as indicated on the CMS-1500, box 31.

   Per 28 Texas Administrative Code §133.307(c)(2)(J), requires that the request shall include "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier . . . and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250" Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the insurance carrier and/or as submitted to the insurance carrier for an appeal in accordance with §133.250. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (J).

   28 Texas Administrative Code §133.307(c) (2) (K), requires that the request shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB" Review of the submitted documentation finds that the request does not include copies of any EOBs for the disputed services. Nor has the requestor provided evidence of insurance carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (K).

28 Texas Administrative Code §133.307(c) (2) (M), requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of all medical records specific to the dates of service in dispute. Although the requestor did submit a copy of an office visit note, the office visit note notates, CPT Code 99245. The Division finds that the requestor submitted insufficient documentation to support that the services were rendered as billed.

3. For the reasons indicated above, the Division finds that the requestor is not entitled to reimbursement for CPT Code 99215 rendered on October 22, 2014.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 9, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.